**ADMISSION AND DISCHARGE PROCEDURE**

**Operational procedure linked to Leeds Transfer of care Policy**

The key messages the reader should note about this document are:

1. This procedure is intended to ensure that service users are admitted to and remain in hospital for no longer than they need by effectively managing the inpatient stay.
2. It ensures that people are cared for in the most appropriate environment and that care is planned to meet the needs and goals of the service user with their full involvement.
3. Planning patient’s service -users transfer/discharge from inpatient care should commence on or before the day of admission to hospital.
4. That joint working and the sharing of responsibility for transfer and discharge from hospital across the whole system is critical to a well-managed and delivered process
5. That all agencies involved in the service users care working collectively is key to reducing length of stay, delayed transfers of care and the likelihood of emergency readmissions.
6. The transfer of care process will focus on the persons needs and both they and their carers should be involved and kept informed of what is happening at all times.
7. That service users and carers expectations as to the purpose of inpatient care are well managed with regards to the options available to them.

**DOCUMENT SUMMARY SHEET**

ALL sections of this form must be completed.

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**1.** **THE PROCEDURE**

* 1. **Background**

The admission, transfer and discharge of a service user to and from inpatient services is a critical function of our services in delivering a needs based and person-centred approach to care. Whilst we work to try to minimise the numbers of people who will require inpatient care it remains an important part of the care pathway for some service users who cannot be safely treated in the community. Ensuring people do not stay in hospital for longer than they need to is however important in both promoting recovery and maintaining patient flow across the care pathway.

An inpatient admission is a multi-disciplinary and inter-agency collaboration to ensure that the needs of the service user are met in the least restrictive way. We aim to develop a care and treatment plan which maintains safety based on goals identified by service users and carers and delivered through collaboration between Trust staff, our partners and service users, their families, carers and significant others i.e. advocates.

By more effectively managing inpatient stays and reducing delays for service users we will improve our overall patient flow. This will in turn reduce both the time taken for those assessed as needing admission to receive this level of care and to ensure that patients receive care as locally as possible.

Each service will have their own bespoke processes for managing admission to hospital based on the needs of their service users. Each service will produce an operating procedure outlining these processes and how they will be managed and monitored for their service. These will form appendices to this over arching procedure.

**1.2 Purpose of the procedure**

The purpose of this procedure is to:

* Describe the minimum standards of practice to be followed to support service users through their admission to hospital to achieve a timely transfer or discharge.

# To ensure that transfers of care are managed using the principles described by the Department of Health high impact changes: managing transfers of care and NICE guidance on transition between inpatient hospital settings and community or care home settings for adults with social care needs

* Describe how we will measure the performance of the Trust and our partners against these standards
* Ensure that it is the agreed needs and goals of the service user which determine the service most appropriate to coordinate their care, and **not** age or diagnosis.
* Set out the overarching principles and standards to support local protocols
* Describe the process to follow to escalate disputes and issues related to transfer and discharge from inpatient care to achieve resolution of these.
* To inform the local working instructions of each ward

**1.3 Objectives of the Procedure**

The objectives of this procedure are:

* To ensure that care delivery is well designed, effective and efficient
* That service users and their carers are given timely and appropriate information to help them plan for discharge at the point of admission so there are no surprises when transfer or discharge takes place
* That service users are treated with respect and dignity throughout their inpatient stay
* To reduce the overall length of stay for people admitted to hospital and to free capacity to eliminate the need for inappropriate out of area placement
* To ensure that potential barriers to discharge are identified as soon as possible and that these are mitigated through effective care planning
* To reduce the numbers of service users clinically ready for discharge whose transfer from hospital is delayed and to reduce the number of days that service users who are reported as delayed are awaiting transfer
* That any areas where gaps in service provision across the care pathways which are creating delays can be identified and escalated appropriately

**1.3 Description of Procedure/Process**

**1.3.1 Roles and Responsibilities**

|  |
| --- |
| **Gatekeeping and admission management**  Each service will identify who will gatekeep patients and determine whether hospital admission is required. The gatekeepers will be expected to have considered all options and alternatives to hospital admission using the principles of the least restrictive environment. Gatekeeping will always take into account the views of patients and their carers / family.  **Care Coordinator**  Service users may already have an identified care coordinator or may be referred for a care coordinator at admission. On admission to hospital, the Care Co-ordinator maintains the lead role.   * + Leads on discharge planning.   + Ensure that all service users have an agreed initial discharge plan within 72 hours   + Ensures that all required care documents are completed   + Liaise with ward to set preliminary discharge dates   + Attend reviews when appropriate   + Develop plan of care for service user post discharge   + Communicate with service user, carers, other clinical teams and agencies regarding planned date of discharge   + Ensure crisis/safety plans are up to date and that these include any relevant information related to hospital admission |

**Ward Team**

* Allocate named nurse and primary nursing team
* Participate in multi-disciplinary team meetings
* Agree initial discharge date for service user
* With the service user and carers identify goals to be met through inpatient admission
* Deliver agreed interventions and review effectiveness of these
* Communicate with service user, carers, other clinical teams and agencies regarding planned date of discharge.
* Identify people clinically ready for discharge who are now delayed and record on Care Director
* Record estimated date of discharge and continue to review this

**Consultant / Responsible Clinician**

* Participate in processes which deliver a purposeful in patient admission.
* Review care delivery with service user and ward team and amend as required to meet agreed goals for admission
* Receive and review weekly information reports for ward activity
* Consider ongoing needs of service user post discharge regarding legal status

**Clinical team Managers**

* Ensure that MDT process is followed for all service users and that all service users have initial date of discharge agreed within 72 hours of admission
* Ensure that all service users have a discharge plan within 72 hours of admission
* Act as an initial point of contact for service users and carers to ensure that they are aware of options for discharge from hospital and discuss any concerns they may have with these.
* Receive and review weekly information reports for ward activity
* Participate in all activities related to capacity and flow.

**Matrons/operational managers**

* Monitor use of the MDT process and make changes to the design of the process as are required
* Be aware of the number of people clinically ready for discharge who have been delayed and assist the wards in care planning to facilitate discharge for these service users.
* Escalate issues related to Delays to Operational Service Managers and Clinical Directors which cannot be resolved.
* Meet with service users and relatives as part of the dispute resolution process and ensure that they are aware of the options available to them and what can be provided for after care.
* Receive and review weekly information reports for ward activity
* Participate in all activities related to capacity and flow.

**Head of Operations/Clinical Lead**

* Understand and report on current bed pressures
* Ensure that processes related to purposeful inpatient admission are implemented across the wards.
* Ensure Multi-disciplinary meetings are implemented across all wards.
* To provide operational overview of demand and capacity and facilitate discharge of service users where specialist input is required
* Understand patterns of bed pressure
* Undertake actions as required when escalation of complex individual cases is required.

**Deputy Director of Care Services/Chief Operating Officer**

* Chair the Inpatient flow oversight group
* Inform the relevant groups/directors and Trust solicitors of potential complex action.

**Adult Social Care**

* Will undertake timely assessments within the Care Act framework of 28 days.
* Will attend discharge and or professionals meetings
* Will engage and liaise proactively with family members in order to formulate appropriate and responsive support plans
* Will work with multi-disciplinary team and family members plus advocates to achieve timely discharge
* Will identify appropriate services to meet eligible need and formulate requests to take to the relevant funding panels for approval.
* The Head of Service for Adult social care will review, edit and approve the relevant codes on behalf of the Director of Adult Social Services for all delays.

**2. Discharge Planning**

The best discharge planning begins at admission. Understanding the purpose of admission helps to determine and set a likely initial date of discharge. An estimated date of discharge should be formulated and recorded on Care Director at the eariest opportunity.

It is expected that most service-users will return to their previous accommodation with the correct support package in place when fit / safe / ready for discharge. A preliminary plan of discharge should be in place within 72 hours of admission and therefore where this is not expected to happen an alternative discharge plan should be developed. This plan should be regularly reviewed and updated as new information comes to light and actions are completed.

To minimise the amount of time the service user stays in hospital the ward team must ensure that all clinically appropriate internal assessments have been completed as soon as possible and that referrals for partners to undertake required assessments take place without delay. All assessments and referrals will be clearly recorded on Care Director.

The following principles should be followed:

* Liaise with the relevant Discharge support service and inform them of the discharge plan and date of discharge
* Community teams should undertake regular in-reach to the wards to identify possible service users who could be given additional support to facilitate early discharge
* Where a Community Treatment Order (CTO) is required, then a referral for an Approved Mental Health Professional (AMHP) is made immediately, with details of discharge plans
* Involve the service user, carer and community teams including partners involved in their care in the discharge plan to and ensure any changes to this are widely communicated and explained.
* Communicate any use of leave with carers and other teams involved in the service user's care and any support needs with this
* Ensure that community follow up is planned within 3 days and that the service user, carer and provider where appropriate are aware of this
* Discharge summary sent to GP within 7 days of discharge

The key principle to be followed in transfer/discharge planning is one of regular and candid discussions operating on a principle of no surprises for the service user and their carers. The transfer/discharge plan will be discussed with the service user and their carer and if there are any changes to this they should be informed. Throughout the planning process the views of the service user will always wherever possible be taken into account and acted upon. The outcome of all assessments should be explained to the service user and where there is disagreement this should be recorded in the clinical record.

It should be made clear from the outset what options are available to service users and also what options are not available and why. This will make clear the expectations from both the Trust and the service user and encourage flexibility with regards to transfer. It should be made clear that where a final outcome from the transfer cannot be immediately achieved, for example transfer to a care home near family or carers that this will remain the long term goal but in the short term a transfer to another placement may be required. In all cases it must be made clear that there is not an option for service users to remain on an acute inpatient ward once they are clinically ready for discharge.

**Accommodation**

Discharge to stable accommodation is likely to improve someone’s recovery and reduce the chance of emergency readmission. It is therefore important that accommodation is considered very carefully as part of transfer/discharge. We must also however recognise that accommodation options are not limitless and there may be a need to compromise. The options which are available to service users should be explained to service users as soon as possible following admission.

Where accommodation has been identified as an issue for a service user a duty to refer should be completed and sent to the local authority to determine whether they have a duty to house the patient. This will give patients access to the housing options service and local authority services who will have a more detailed knowledge of the options available and the systems in place to assist service users to get accommodation. It should be discussed with the service user that there may be a need for them to move to available accommodation whilst they wait in the community for their preferred option. This may include the need to move into temporary accommodation.

**Non UK nationals**

Non UK nationals may not be entitled to any support with regards to housing or benefits on transfer from hospital and this should be established as soon as possible following admission. The discharge facilitators will normally be able to help the ward staff in establishing an individual’s right to support.

Legal Status post discharge should be established and where necessary this should be checked with the border agency.

**3 Day Follow Up**

It is considered best practice for all service users to receive contact post discharge within 3 days from the allocated care coordinator or nominated person. If a service user is to be discharged to another area outside of Leeds and will be remaining there contact should be made with the local mental health provider and arrangements for follow up agreed.

Prior to discharge an up to date address and telephone number for the service users should be obtained and this recorded on the information system.

**NHS Continuing Care**

The NHS is required to assess a service-user’s needs utilising the National Framework for NHS continuing healthcare and NHS funded nursing care.

If the screening does not identify eligibility for a full assessment then the service-user must be informed of the outcome and the screening tool retained in the notes, dated and signed by the clinician who undertook the assessment

Where full assessment is indicated, the Continuing Care link worker will then contact the ward, patient and carer/significant other to arrange a full assessment of eligibility utilising the Decision Support Tool – This is not a decision tool, but provides documentary evidence that consideration has been given to eligibility in all 11 domains. This assessment will then be taken to Panel for a decision.

Communication relating to the continuity of medical care will follow the existing practice and procedures.

**3. Delays for service users who are “Clinically ready for discharge”**

A delay in the transfer of care occurs when:

* The service user is deemed Clinically ready or medically optimised for transfer/discharge by the Multi-Disciplinary Team. In either the MDT review or a CPA meeting. The decision that the level of care being provided i.e. in an acute in-patient setting is no longer needed should be taken by the Multi-Disciplinary Team (MDT) and should be documented in the care record and fully explained to the individual and their carer
* The service-user / carer and other agencies involved have been informed and advised to look for placements and accommodation and none have yet been sourced or the relevant assessments from providers have not been undertaken.
* Support has been offered by either Adult Social Care, Accommodation Gateway or relevant agency to source placements and there is currently no available provision to meet need.
* All required referrals have been completed.
* Following a 14 working day period and no placement /accommodation has been found. MDT to record on Care Director the delay reason and agencies responsible.

All Service users transferring between wards providing the same level of care do not count as a delay. For the transfer of care to be recorded as delayed the service user must be clinically ready for discharge and safe to transfer.

The service user and where appropriate their carers will be informed that continued inpatient care is no longer required and that they are now being reported as Clinically ready for discharge but delayed. The service user and their carers will be informed by the ward team of the plan for transfer from inpatient care and given the opportunity to discuss this and any concerns that they might have. A clear plan including next steps and timescales will be set with the service user and their carer and this will be recorded in the clinical record.

In the majority of cases the delay in facilitating discharge will be frustrating for service users and their carers and the reasons for the delay and the actions being taken will be explained to them. Where actions are needed to be taken by the service user or their carers in conjunction with Trust teams this should be explained to them and the reasons for these actions need to be taken. These conversations will be recorded in the clinical record. Any difficulties that the service user or carers may have in undertaking any actions will be considered and where appropriate support put in place to help them with this. This may include support from ward and community staff as well as 3rd Sector partners, advocacy and Adult Social Care.

The ward and community teams will ensure that there are regular, at least weekly, updates given to the service user and the carers with regards to their transfer and the delay. These updates will focus on the actions that have been taken and will include an estimate of when transfer will happen. Any changes to the estimated date of transfer will be explained to the service user and the reasons for this.

Where a delay is due to the service user and / or carer disagreeing with the proposed plan and a mutually agreeable plan for transfer from inpatient care cannot be achieved this should be reported as a dispute and the escalation process instigated. The service user and carer will be informed that this will be escalated.

**3.1 Working together to avoid Delay.**

The care coordinator, ward team, and discharge support colleagues will work constructively with colleagues from partner agencies to facilitate a smooth transfer of care for the service user. Understanding and identifying possible causes of delays is critical to avoiding these through appropriate care planning. In all cases the service user and carers should be involved in the care planning and the services need to be clear with regards to the expectations of the service user and what can be achieved during an inpatient admission.

Support for the service user with accommodation delays is available through the a number of statutory and third sector agencies who have detailed specialist knowledge of what is available to support finding accommodation. The local authority can provide priority for housing, identify possible accommodation and support people with gaining bonds for private lets for people living in their area.

Where delays and blockages occur within our internal systems or between organisations these should in the first instance try to be resolved by the care coordinator and ward team. Where this is not possible escalation of the issues should be made through the management structure. (See flowchart). Prior to any escalation it will be expected that all possible solutions will have been explored and documented as to why they could not be implemented to remove the delay.

In some cases delays will occur because the service required by the service users to facilitate transfer is not available. Issues related to the commissioning of services should be immediately raised with the appropriate service manager for discussion with the Integrated Care service and Adult Social Care.

**3.2 Recording a delay for those Clinically ready for discharge**

Once a Delay has been identified by the MDT this must be recorded on Care Director using the agreed process. If a service user is not recorded as clinically ready for discharge and delayed on Care director this will not be reported as part of the Trust’s submission and will not be included as part of the Delayed transfer of care review process. For guidance on how to record this on Care Director staff can access the guide on staffnet or the bed management team.

**3.3 Review of service users clinically ready for Discharge and delayed**

All delay will be reviewed in the appropriate forum for the service lines, any actions which either need to be taken or have been taken to facilitate discharge should be agreed and a member of the ward or bed management team nominated to take action within an agreed timescale.

**3.4 When is a Delay Cancelled?**

A delay will be cancelled when one of the following occurs:

* The service user is transferred from inpatient care. Discharging a service user on Care Director will automatically cancel the delay however transfer of the service user to another ward within the Trust will require the delay to be manually ended on Care Director.
* The service user’s clinical presentation changes so that they are no longer considered to be clinically ready for discharge. This must be agreed by the multi-disciplinary team and recorded in the service user’s clinical records. Care Director should be completed giving the date that the Delay ceased.

Where the service users clinical presentation changes it is important that the care coordinator and others involved in their care are made aware of this. The service user and carers will be informed that they are no longer being recorded as a delay.

**Disputes and Escalations**

Whilst the majority of admissions will result in a smooth transfer of care from inpatient services there will be occasions when the ward team will require support in managing disputes. All efforts should be made at each level to achieve a mutually acceptable agreed outcome between the service user, the Trust and carers and for disputes to be avoided. On many occasions disputes are created by a mismatch of expectations and honest, good quality and regular communication can help to avoid this. Trust staff should be clear and open with service users and their carers with regards to their options for transfer and that remaining on the ward is not an option in most cases. Service users do not have a right to occupy an NHS bed for an indefinite period of time.

In its guidance ‘NHS responsibility for meeting continuing care needs’ the Department of Health states that:

‘Where a person has been assessed as needing care in a nursing home or residential care home arranged by a local authority, he or she has the right under the direction of control to choose within limits on cost and assessed needs which home he or she moves into. *Where however, a place in a particular home is unlikely to be available in the near future, it may be necessary for the patient to be discharged to another home until a place is available*.’

Before a dispute can be raised by the ward the following must have taken place:

* All necessary assessments have been completed by the multi-disciplinary team and copies shared with the service user and carer and prospective providers where appropriate
* Discharge to the service user’s own home has been fully explored and there is agreement that this is not appropriate
* Service users and carers have been provided with information to help them find a suitable placement
* Liaison with the service user and carers has taken place with a member of the nursing team
* Funding from the Local Authority and / or ICS (if the service user is not self-funding) has been confirmed.
* It has been confirmed that the service user remains clinically ready or medically optimised for discharge

Where a dispute regarding transfers from inpatient care has been identified the ward team will organise a meeting with the service user and where appropriate carer or advocate to discuss their options. The meeting should involve appropriate professionals. The ward manager will confirm the following with the service user:

* That all information has been provided to the service user and carers
* The reason for the dispute
* The options for discharge and possible destinations
* That a further 7 days will be allowed to arrange transfer of care from inpatient services.

The ward manager will ensure that all those at the meeting are given the opportunity to speak and will where possible answer any questions in an open and honest way. The ward manager will ensure that the discussion is recorded and any actions agreed are allocated with a timescale for completion.

If after 7 days the service user has not been transferred from the inpatient ward and transfer is not imminent then the service should escalate this through the matron to the Head of operations. Prior to this the Matron will ensure that all risks have been considered and reviewed, that the service user remains medically fit for discharge, confirms all available options for discharge and that all reasonable steps have been taken to resolve the dispute. The Head of Operations will arrange a meeting with the service user and carer. If following the meeting a reasonable discharge date cannot be mutually agreed then the Head of Operations will escalate to the Deputy Director for Care Delivery who if required agrees that legal proceedings should be instigated then a meeting with the service users and carers should be organised to discuss this within 5 days. At this point the Deputy Director for Care delivery should inform the Chief Operating Operator and Trust solicitors.

## At the final review meeting the Deputy Director for Care delivery should recap all the steps which have been taken and the reason that the Trust is considering taking legal action. It should be made clear that the Trust is considering taking this action to safeguard the wellbeing of other service-users by ensuring that beds are available locally. All reasonable steps should be taken to resolve the dispute and the date that the service user must be by should be confirmed with the service user and carers. All discussions and actions will be recorded.

## ****4. Escalation flow chart****

Steps 1 - Providing standard information and support

**Where a dispute regarding transfers from inpatient care has been identified the ward team will organise a meeting with the service user and where appropriate carer or advocate to discuss their options. The meeting should involve appropriate professionals. The ward manager will confirm the following with the service user:**

* **That all information has been provided to the service user and carers**
* **The reason for the dispute**
* **The options for discharge and possible destinations**
* **That a further 7 days will be allowed to arrange transfer of care from inpatient services.**

**The ward manager will ensure that all those at the meeting are given the opportunity to speak and will where possible answer any questions in an open and honest way. The ward manager will ensure that the discussion is recorded and any actions agreed are allocated with a timescale for completion.**

Steps 1 - Providing standard information and support

**If after 7 days the service user has not been transferred from the inpatient ward and transfer is not imminent then the clinical team via the Matron will escalate to the Head of Operations and the Head of Service (adult social care) will be made aware of the dispute. Prior to this the Matron will ensure that all risks have been considered and reviewed, that the service user remains clinically ready for discharge, confirms all available options for discharge and that all reasonable steps have been taken to resolve the dispute.**

**The Head of operations will arrange a meeting with the service user and carer. If following the meeting a reasonable discharge date cannot be mutually agreed then the Head of operations will escalate to the Deputy Director of Care delivery who if required agrees that legal proceedings should be instigated then a meeting with the service users and carers should be organised to discuss this within 5 days. At this point the Deputy Director for Care delivery should inform the Chief Operating Operator and Trust solicitors.**

**At the final review meeting the Deputy Director for Care delivery should recap all the steps which have been taken and the reason that the Trust is considering taking legal action. It should be made clear that the Trust is considering taking this action to safeguard the wellbeing of other service-user by ensuring that beds are available locally. All reasonable steps should be taken to resolve the dispute and the date that the service user must be transferred by should be confirmed with the service user and carers. All discussions and actions will be recorded.**

* 1. meeting, appendix 1 – Sample letter to service user on admission

Appendix I sample letter Admission letter Older Adult

Dear

Our goal is to provide very good care in every aspect of your hospital stay. Our staff are committed to working together as a team to coordinate your care and provide as much information as you need about your care. Your named nurse will review your care needs on a daily basis with the rest of the ward team to put in place a plan to transfer your care to right service to support your ongoing recovery.

We need your help to make sure that your stay in hospital is no longer than is needed. We aim to minimise your dependence on the ward and in so doing possibly increase demand on social and community care. We will also be able to make sure that we will always have capacity for people who need the level of care that can only our wards can offer.

When you are ready for discharge or transfer the ward will have already considered your on-going care provision and will have discussed this with you and your community care coordinator. Between the ward and your community care coordinator we will have undertaken all the required assessments to plan your future care and will be able to tell you the options that are available to you.

If your preferred choice is not available at the point you are ready for discharge we will offer an alternative location or care provider whilst you await availability of their first choice. The ward team, adult social care and our others partners will continue to support you in the community to offer support.

If you have any concerns with this please discuss these with your named nurse or care coordinator or in your ward review.

Yours sincerely

Operational Service Manager

Inpatient services

Appendix 1 Sample Admission Letter working age Adult

Dear

During your inpatient admission our goal is to provide very good care in every aspect of your hospital stay. Our staff is committed to working together, as a team, to coordinate your care and provide as much information as you need about your treatment and care needs. Your Primary Nurse will review your treatment plan with you, other members of the ward team and our community colleagues on a regular basis so that we can put in place a plan to transfer your care to right service to support your ongoing recovery upon discharge from hospital.

In order to do this, we need your help to make sure that your stay in hospital is no longer than is needed. There are two reasons for this: 1. We know that the vast majority of people make the best recovery at home supported by family, friends and professional community mental health staff once the acute phase of an illness is brought under control; 2. Hospital beds need to be available for those who are in greatest need. Creating capacity by transferring people home when they are well enough helps us to ensure that a local bed is always available when it is required.

Discharge planning takes place upon your admission and is kept under consideration throughout your treatment in hospital; you will always be included in this process. Your ward Consultant, Primary Nurse, Occupational Therapist (if appropriate) and Community Care Coordinator will help you by paying close attention to any matters that might affect your discharge so that everything possible can be done to prevent these being a barrier to you leaving hospital at the right time. *For some people having accommodation to go to may be an issue. If you think this may be a problem for you, please ensure that you discuss it with a member of staff at the earliest opportunity. We will do all that we can to assist you to have settled accommodation by the time of discharge and your cooperation with this process is very important. Of course, we always hope that your accommodation needs are in place by the time you are ready for leaving hospital but if this is not the case, then you will need to be discharged from hospital to present at Leeds City Council Housing Options Team who may, after assessment, assist you to find emergency accommodation and continue to support you to find permanent accommodation*. ***If you have accommodation when you come into hospital you should not give this up during your admission without first discussing it with a member of the team***.

Before you are discharged you will have a clear plan of the arrangements for your ongoing treatment and how to make contact should you need any urgent support.

If you have any concerns about any of the matters contained in this letter then please discuss it with your Primary Nurse or Care Coordinator or in your ward review.

Yours sincerely

Operational Service Manager

Inpatient services

Appendix 1 – Sample letter for discharge meeting

Date

Dear

Following the telephone conversation on the XXXX OR> we have been unable to contact you by telephone on the XXX, XXX, and XXX so in order to facilitate your relatives discharge. I am writing to invite you to a meeting at (TIME) on (DATE) in (LOCATION).

The purpose of the meeting is to discuss the progress made in finding a suitable residential or nursing home placement care provider for you/person’s name. Members of the team caring for you/person’s name will also be invited to participate in the meeting. You may wish to bring family members, a close friend or an advocate to the meeting and you are very welcome to do so. The Patient Advocacy and Liaison Service (PALS) may be able to provide an advocate for you and they can be contacted on (contact number).

It is hoped that you will have made some progress in identifying discharge options. You may have already found a suitable residential or nursing home care provider. If so, please continue discussions with them and allocated social worker the Ward Manager or Matron. Please bring details of any placements and/or questions you may have to our meeting. If you are unable to attend the meeting please contact me on the telephone number above to discuss an alternative time.

Every effort will be made to arrange a convenient date for all parties to meet within the constraints of this busy unit and to be flexible in the light of your domestic arrangements. It is important that we hear from you as soon as possible in order to arrange a date for a safe discharge from the Hospital. If you are unable to meet for any reason please contact thenamed person above. In the meantime the clinical will continue to work with you/ you’re relative to facilitate discharge. (If no contact by telephone)

Please can you confirm attendance at the above meeting? If you have not contacted us the meeting will proceed to discuss the discharge plan. If you have any queries, or concerns, please do not hesitate to contact us on XXX contact name XXXX

Yours sincerely

Ward Manager/Discharge and Capacity lead

Appendix 1 Sample letter 3

Date

Dear

The meeting today was to discuss the need for you/person’s name to be discharged now that inpatient hospital care is no longer required. I am sorry you were unable to attend. All required assessments of [your/person’s name] needs are now complete and you/he/she is ready for discharge.

In discussion with the multi-disciplinary team it has been agreed that your/person’s name needs would be best met by returning home with appropriate domiciliary care moving into a to a care home with/without nursing adapt as appropriate. The following actions were agreed at the meeting: All agreements to funding for social/health care needs require approval by the Local Authority/\Integrated Care Service and will normally be based on the rate which the Local Authority/Integrated care service expect to pay for this type of care support and your allocated Social Care representative/NHS Continuing Healthcare Nurse will supply/have supplied you with options available within this range. If you are unable to identify any available care option that you consider meets your/person’s name requirements or your preferred option is not currently available, you/person’s name may need to temporarily accept an interim care home/care provider whilst you wait for your preferred choice. A Social Care representative will support you. We have made arrangements to meet with you again on [Date,

Yours sincerely,

Ward Manager /Matron [Trust Name] Tel: direct line

Time, venue] If you have any queries, or concerns, please do not hesitate to contact me.

**Appendix 2 Service Line Criteria**

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| **Service Line:** | **Adult Acute Mental Health services** |
| **Criteria for Admission** | Patients who are over 18 years of age and are registered with a GP in Leeds. Whilst there is no upper age limit set patients over the age of 65 would normally be admitted to older people’s services though this will depend on whether this is clinically the most appropriate environment to receive care. Te service uses the national ‘Who pays’ guidance to determine whether Leeds has a responsibility to provide in patient care for a person. |
| **Process for Referral** | All referrals are made through the capacity and discharge support service (CADSS) and will be logged on Care Director. Only those referrals which have been gate kept via CRISS/ALPS will be accepted. |
| **Gatekeeping arrangements** | All referrals will be gate kept via CRISS and S136 service or ALPS services. PICU gate keep all PICU admissions including thise made out of area. |
| **Bed Management process** | Bed management referrals are discussed each morning with the CADSS bed manager, CRISS shift coordinator, matrons, social work andAMPH duty manager. Referrals are prioritised and allocated available beds following the morning capacity calls which are held with the wards. The bed management process is undertaken by the bed manager in normal hours and the CRISS shift coordinator out of normal hours. These people will be responsible for seeking approval to use spot purchased out of area beds and manage the referral process with the providers. The bed manager will inform and update all thse concerned with the referral with actions being taken and outcomes. |
| **Process for managing delays in admission** | The adult acute service has an escalation process in place which has been agreed via clinical governance outlining actions to be taken and who should take these when admission is delayed beyond 12 hours of the decision to admit being made. All delays to admission are discussed daily with relevant clinical teams and this is undertaken by the bed manager. All delays to admission should be recorded on Datix and this information is reviewed at the service clinical governance meeting. |
| **Process for managing Delays in discharge** | Once a delay has been agreed with the ward MDT this is recorded as such on care director using the nationally agreed codes. The wards use the Purposeful inpatient admission (PIPA) process to review all actions needing to be taken to facilitate discharge for each service users every morning. Actions are idedtified and monitored via this process. All delays are reviewed at a weekly meeting with colleagues from adult social care and housing to ensure the wider system is undertaking necessary actions to support discharge. A further weekly capacity meeting is held and chaired by the Matrons where each patient is discussed and reasons for delays discussed and alternative management plans agreed. Delays are reported to the wider health and social care system using the OPEL process. Wards can also nominate patients to be reviewed at a complex case review where each case is reviewed clinically and actions agreed |
| **Any Escalation processes** | Escalation processes are in place for managing delays to admission and requests for out of area admission. There is an escalation process built into the OPEL reporting process. |

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| **Service Line:** | **Liaison and Perinatal Service**  **Inpatient admission to Mother and Baby unit.** |
| **Criteria for Admission** | Women experiencing significant  mental health difficulties during pregnancy or if they have a baby less than 12 months of age.  • Postpartum Psychosis or previous history of  • Diagnosis of Bipolar Affective Disorder, Schizo-affective disorder or other psychoses  • Moderate or severe antenatal/postnatal depression or anxiety disorders including previous severe depressive episode/post natal depression-requiring treatment in hospital/secondarycare.  • Mothers with these conditions under the age of 18 are accepted if there is a significant perinatal mental illness and they are likely to be the infant’s principal carer. Inpatient Mother and Baby Units are suitable for the admission of a young mother but the admission will be managed in collaboration with Child and Adolescent Mental Health Services (CAMHS) and Social Services.  • Women in the antenatal period over 32 weeks gestation |
| **Process for Referral** | Completion of the Universal Mother and Baby Unit Referral Form available via the NHS Capacity Planning and Monitoring System (CPMS)  <https://perinatal.cpms.necsu.nhs.uk/>  Urgent referrals should also be discussed over the phone.  As well as the completed from, an up to date risk assessment is also required.  The form and any additional information is sent to a central email account [leedsmbu.lypft@nhs.net](mailto:leedsmbu.lypft@nhs.net) and discussed by the MDT.  All information is logged and recorded on CareDirector.  The information provided is discussed by the MDT. The decision regarding appropriateness for admission is based on the clinical assessment in the context of discussion with the multidisciplinary team. This will include a risk assessment prior to admission to determine if is safe and in the best interests of the child to be admitted to the unit.  If the decision is made to admit the patient and a bed is available then admission should take place as soon as can be arranged and the referring agency will be informed.  If no bed is available or the mother cannot be accepted for other reasons then discussion will take place as to other options regarding appropriate care for the mother.  Admissions can be accepted 24 hours a day, 7 days a week. This is necessary to avoid delay in admission and the intermediate use of admission of mothers to other in-patient facilities, without their baby (except in exceptional circumstances). |
| **Gatekeeping arrangements** | If the patient and referring team are outside of the Yorkshire and Humber region, approval from the local Mother and Baby Unit is required before the referral can be accepted.  All referrrals are discussed and gate kept by the Mother and Baby Unit multidisciplinary team.  For admissions out of hours the nurse in charge of the Mother and Baby Unit is able to make decisions. Discussion with the charge nurse/clinical team manager/consultatnt psychiatrist is encouraged if the presentation is complex.  If the child is in the care of the Local Authority or subject to a child protection or family support plan, all discussions must include the Social Worker for the child in order to gain consent/agreement for the child’s placement. |
| **Bed Management process** | Referrals are discussed daily by multidisciplinary team including the medical team, ward manager, charge nurse and nurse in charge of the ward. The professionals will agree whether any additional information or discussion with the referring team is required and will delegate these tasks.  In complex cases where the request for admission is non-urgent, and the case for admission is not clear, multidisciplinary assessment will be arranged to take place on the Mother and Baby Unit or at the mother’s current place of residence, whichever is most suited to the woman’s needs.  Assessment and decisions regarding admission will include family members if this accords with the mother’s wishes regarding involvement of the extended family. Where father has parental responsibility his consent should be sought for the child to stay on the Unit with the mother. |
| **Process for managing delays in admission** | If no bed is available or if the mother cannot be accepted for other reasons then discussion will take place as to other options regarding appropriate care for the mother.  This may include placement in a Mother and Baby unit outside Leeds. This would be the preferred option in most cases. The completed CPMS referral form, risk assessment and any additional information is discussed and sent to the nearest Mother and Baby Unit with available beds and discussion with their team regarding admission is required.  In some cases it may be necessary to admit the mother to an adult acute inpatient ward and for the baby to be cared for by family or children’s social services.  All discussions and decisions are recorded on care director. |
| **Process for managing Delays in discharge** | Delays in discharges are discussed and agreed with the Mother and Baby Unit multidisciplinary team and reviewed at least twice weekly. This will include involvement and advice from social workers with particular focus on housing.  The delay is recorded on care director using the relevant process and codes. |
| **Any Escalation processes** | The ward manager, consultant psychiatrist and clinical operational manager will be made aware of any issues related to referrals to the Mother and Baby Unit including and delays to admission and discharge.  Where there is disagreement, the referrer may request a further clinical assessment by another MBU within the wider Strategic Clinical Network area, or in a neighbouring region where there is only one MBU in the SCN geography. |

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| **Service Line:** | **Older People’s service Line**  **Inpatient admission to OPS acute wards and Dementia services** |
| **Criteria for Admission** | People with Dementia, regardless of age.  People over 65 with acute mental health care needs  It may be agreed that someone under 65 may be best suited to receive care on our wards for person centred reasons, an example may be where frailty is a factor (this is managed on a case by case basis).  For People registered with a Leeds GP. |
| **Process for Referral** | Referrals for admission should be made through the single point of access who will direct the referrer to the bed manager after taking and recording demographic details on care director. The bed manager will take details from the referrer including the current clinical position and the type of bed which is being requested. The referrer must specify which bed is being requested. Normally referrals will come from one of the gate keeping services however may be made by any clinicians once the admission has been agreed by a gatekeeper. |
| **Gatekeeping arrangements** | Whilst the OPS Urgent Care Teams do not hold a gatekeeping function alternatives to hospital admission (IHTT/ICHTT/CDWT) should be considered by the referrer as part of bed management process |
| **Bed Management process** | The bed manager will take lead responsibility for allocating beds duing normal office hours. Outside these hours the CRISS shift coordinator will lead bed management. Once details of the referral have been collected and recorded on to care director the bed manager will contact the senor nurse for in patient OPS services and discuss the referral. Where a bed is immediately available this will be allocated and the referral and ward informed by the bed manager. Where there is a delay to admission the referrer will be contacted and informed of the delay with an approximate timescale.  All referrals are reviewed as part f the daily capacity meeting with laiason, IHTT, ICHTT and ward managers and operational managers. This meeting will prioritise referrals and agree actions to be taken to allow admission. The bed manager will updates those not attending the meeting of the outcomes.  If agreed the bed manager make referrals to private providers to secure an out of area bed. |
| **Process for managing delays in admission** | All delays to admission will be discussed at the morning capacity meeting with operational and ward managers with liaison psychiatry and IHTT/ICHTT. Actions will be agreed to, where possible, free capacity.  The bed manager will continue to update referrals on the likely timescales for admission.  Where admission is delayed for more than 12 hours from the decision to admit the referring team should complete a datix.  Where delays to admission cannot continue to be safely managed these should be escalated using the agreed escalation procedure.  Out of area admission will be sought if agreed by the head of operations for OPS. |
| **Process for managing Delays in discharge** | The ops discharge team join a twice weekly delay meeting with Adult social care partners. To discuss those service users who have been deemend fit for discharge and to identify and agree who is a delayed discharge.Once a delay has been agreed the discharge team record as such on care director using the nationally agreed codes.The twice weekly delay meeting (Dtoc) process is to review all actions needing to be taken to facilitate discharge for each service users.. Actions are idedtified and monitored via this process. All delays are reviewed at this twice weekly meeting with colleagues from adult social care to ensure the wider system is undertaking necessary actions to support discharge. A further Operational delay group weekly meeting is held with Operational leads from LYPFT & ASC and OPS matrons ,and chaired by the Discharge manager where each patient is discussed and reasons for delays discussed and alternative management plans agreed where each case is reviewed clinically and actions agreed. Updates from the above meetings are recorded on individual service-user case notes on care director, and feedback verbally by the discharge team in MDT reviews. |
| **Any Escalation processes** | Escalation proesses are identified in the above processes. |

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| **Service Line:** | **Forensic Services**  **Inpatient admission to Forensic wards, Clifton** |
| **Criteria for Admission** | 18-65 year old male and female service users with mental illness that reside within our patch or have a gp registration within West Yorkshire Secure ICS. Admissions are sent through WY adult secure provider collaborative SPA team. We accept referrals from Prison, PICU, medium secure services and at times recall of section 41 service users. |
| **Process for Referral** | Referrals should be made through the SPA (single point of access) who will collate the information and send the referral to the appropriate secure provider to consider and discuss the referral in the site weeky referral meeting. |
| **Gatekeeping arrangements** | Referrals are collated by WY Secure SPA team that are sent to our clinical admin team, who then send on to the wider clinical leadership team team. The referral documents are reviewed, discussed as part of our referrals meeting. The gate keeping assessments are then planned as an MDT, then conducting joint assessment with medic, nurse and / or Occupational therapy, Psychologist dependant on the need. |
| **Bed Management process** | Following completion of the gate keeping assessment and receipt of gate keeping assessment report to the SPA. There will be a pre-admission meeting completed by the ward team, external stakeholders as required and if appropriate the service user. The receiving team will agree or confirm a date for admission informing those as part of the referral meeting. If there are delays or a lack of bed the accepted referral will go on to the wards waiting list until admitted. |
| **Process for managing delays in admission** | The provider collaborative has an escalation policy. It would be dependent what the delay is caused by, discussions would take place in the weekly bed management meeting. |
| **Process for managing Delays in discharge** | The provider collaborative has an escalation policy. Professionals involved would be meeting to discuss what the barriers to discharge were and trying to overcome these. |
| **Any Escalation processes** | See above, but also raised with case managers. |

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| **Service Line:** | **Forensic Service Line**  **Inpatient admission to Forensic wards, Clifton House** |
| **Criteria for Admission** | 18-65 year old male and female service users with mental illness that reside within our patch or have a gp registration within our humber coast and vale catchment area. Admissions are sent through Humber coast and vale adult secure provider collaborative SPA team. We accept referrals from Prison, PICU, medium secure services and at times recall of section 41 service users. |
| **Process for Referral** | Referrals should be made through the SPA (single point of access) who will collate the information and send the referral to the appropriate secure provider to consider and discuss the referral in the site weeky referral meeting. |
| **Gatekeeping arrangements** | Referrals are collated by Humber coast and vale SPA team that are sent to our clinical admin team, who then send on to the wider clinical leadership team team. The referral documents are reviewed, discussed as part of our referrals meeting. The gate keeping assessments are then planned as an MDT, then conducting joint assessment with medic, nurse and / or Occupational therapy, Psychologist dependant on the need. |
| **Bed Management process** | Following completion of the gate keeping assessment and receipt of gate keeping assessment report to the SPA. There will be a pre-admission meeting completed by the ward team, external stakeholders as required and if appropriate the service user. The receiving team will agree or confirm a date for admission informing those as part of the referral meeting. If there are delays or a lack of bed the accepted referral will go on to the wards waiting list until admitted. |
| **Process for managing delays in admission** | The provider collaborative has an escalation policy. It would be dependent what the delay is caused by, discussions would take place in the weekly bed management meeting. |
| **Process for managing Delays in discharge** | The provider collaborative has an escalation policy. Professionals involved would be meeting to discuss what the barriers to discharge were and trying to overcome these. |
| **Any Escalation processes** | See above, but also raised with case managers. |

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| **Service Line:** | **Learning Disability service Line**  **Inpatient admission to Respite & complex care wards** |
| **Criteria for Admission** | Patients who have agreement from the Leeds LD respite panel to receive health based LD respite |
| **Process for Referral** | Agreed via the Leeds wide respite care panel. |
| **Gatekeeping arrangements** | Leeds wide respite care panel |
| **Bed Management process** | Patients are allocated respite placements on a regular basis as agreed. Patients will be admitted to the most appropriate respite service to meet their individual needs. |
| **Process for managing delays in admission** | All respite placements are agreed in advance and therefore there is no elective admissions to this service and no delays. |
| **Process for managing Delays in discharge** | Respite is agreed for a specified amount of time and admissions are for this length of time. There are therefore no delays to transfer. |
| **Any Escalation processes** | None. |

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| **Service Line:** | **Child and Adolescent service Line**  **Inpatient admission to Red Kite View** |
| **Criteria for Admission** | Young people age 13-17 with complex and severe mental health difficulties that cannot be managed safely in the community. |
| **Process for Referral** | Referral forms are sent to the West Yorkshire referrals inbox, which is managed by Red Kite View admin staff with oversight from the WY CYP PC. For GAU, emergency referrals are responded to within 4 hours, urgent within 48 hours and routine within 7 days. For PICU, emergency referrals are responded to within 2 hours and urgent within 12 hours. |
| **Gatekeeping arrangements** | Red Kite View are responsible for completing access assessments for all young people from West Yorkshire, who are referred for inpatient mental health services. Oversight is provided by the WY CYP PC including young people who are placed OOA. |
| **Bed Management process** | Weekly Inpatient Oversight Panel meetings, including representation from RKV, WY CYP PC and service managers who cover the relevant areas of WY (Leeds, Bradford, Calderdale & Kirklees and Wakefield). New referrals, young people at risk of admission, , current inpatients and those placed OOA are all discussed to ensure effective clinical flow. |
| **Process for managing delays in admission** | The WY CYP PC has an escalation policy. It would be dependent what the delay is caused by, discussions would take place in the weekly Pathway Meeting along with the weekly Inpatient Oversight Panel meeting. |
| **Process for managing Delays in discharge** | There is a Pathway of Concern process which is managed by the WY CYP PC and involves clinical colleagues, to discuss any delayed discharges. There is also a weekly Pathway Meeting for more senior operataional discussions around delayed discharges including requests for support. |
| **Any Escalation processes** | The formal escalation process is to be written between RKV and the WY CYP PC. |

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| **Service Line:** | **Child and Adolescent service Line**  **Inpatient admission to Mill Lodge** |
| **Criteria for Admission** | Young people age 13-18 with complex and severe mental health difficulties that cannot be managed safely in the community. |
| **Process for Referral** | Referral forms (known as form 1’s) are sent to the Mill Lodge referrals inbox. In area emergency referrals are responded to within 4 hours, urgent within 72 hours and routine as soon as practicable. |
| **Gatekeeping arrangements** | The Humber and North Yorkshire provider collaborative have a case manager for CAMHS who should be aware of all appropriate referrals to Mill Lodge and its sister service, Inspire in Hull. |
| **Bed Management process** | Referrals are discussed at the weekly bed management meeting which is held with the provider collaborative and representatives from the two provider services. Waiting lists and any young people ‘out of natural clinical flow’ are also discussed regularly. Bed occupancy rates are also reported on at this meeting. |
| **Process for managing delays in admission** | The provider collaborative has an escalation policy. It would be dependent what the delay is caused by, discussions would take place in the weekly bed management meeting. |
| **Process for managing Delays in discharge** | The provider collaborative has an escalation policy. Professionals involved would be meeting to discuss what the barriers to discharge were and trying to overcome these. |
| **Any Escalation processes** | See above. |

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| **Service Line:** | **Liaison Psychiatry & Perinatal Service Line**  **Inpatient admission to National Institute for Psychological medicine** |
| **Criteria for Admission** | Adult >18 with no upper age limit  Registered with a GP in Leeds for local list.  Registered with a GP in UK for national list.  Capacity to consent to informal admission (no patients admitted under MHA)  Planned admissions only- no acute mental or physical health conditions (these should be optimised before considering planned admission)  NICPM manages patients with:   1. Severe and complex persistent physical symptoms and medically unexplained symptoms 2. Severe and complex ME/CFS 3. Patients with long-term chronic physical health conditions (LTC) where psychological difficulties impact on the LTC and vice versa   Previous investigations of persistent physical symptoms completed.  Evidence of community, secondary and specialist involvement but without improvement or inaccessibility of the above because of severe disability |
| **Process for Referral** | Information on trust website  Referrer to contact NICPM via generic referral email with detailed letter addressed to Consultant Psychiatrist and CTM, highlighting patient’s difficulties and ways they meet criteria. |
| **Gatekeeping arrangements** | Beds are gatekept solely by NICPM.  Two lists- one for Leeds (4 beds) and one for Out of Area (OOA) (4 beds)  Referrals are discussed for suitability at team admissions planning meeting weekly.  If suitable, accepted onto waiting list and Admission Referral Form created |
| **Bed Management process** | Waiting list and admissions planning discussed at weekly admissions planning meeting.  Pre-admission assessment completed one to two weeks before planned admission.  No clinical expedition of patients on the waiting list- all patients referred have severe and complex needs |
| **Process for managing delays in admission** | Assessed case-by-case as admissions are planned at least two weeks in advance.  If patients unwilling/unable to accept a bed at the time it is offered, the bed will be offered to the next patient on the list.  A decision will be made about ongoing suitability to remain on the waiting list regarding the patient who has not been able to accept the offer of the bed.  Depending on circumstances and whether patient is out of area or not, may discuss alternative service input such as outpatients or psychotherapy. |
| **Process for managing Delays in discharge** | Discharges are planned with the patient and team in the weekly MDT.  If barriers to discharge are identified, these are addressed via the MDT, contacting appropriate services, the patient’s GP and/or ICB.  This can take longer if the patient is out of area or needs a complex care package. |
| **Any Escalation processes** | Professionals meetings/CPA with local providers and agencies. Discussion with operations manager.  DTOC cases to be discussed with operations manager and Head of Operations |

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| **Service Line:** | **Regional Eating Disorder and Rehabilitation and Gender service Line**  **Inpatient admission to Eating Disorder unit.** |
| **Criteria for Admission** | Anorexia Nervosa   * Body Mass Index (BMI) >15kg/m2 * Physically stable: Biochemistry, ECG * Low risk of refeeding syndrome   Bulimia Nervosa   * Daily frequency of bingeing and purging * Physically stable: Biochemistry, ECG |
| **Process for Referral** | Connect use 3 referral forms. Internal (community team to ward) referrals are made using the transition referral form. Referrals from external services are made using the Connect service referral form. Out of Area referrals use the out of area referral form.  Referrals are discussed and accepted or declined at the weekly ward and community team meetings.  All referral decisions are recorded on care director. |
| **Gatekeeping arrangements** | n/a |
| **Bed Management process** | Bed occupancy and flow are discussed at the weekly inpatient and community meetings.  The fortnightly Connect Oversight Panel (COP) meeting provides operational oversight and monitoring of bed flow and management using a bed management tracker. |
| **Process for managing delays in admission** | For service users in hospital beds the service follows the Medical Emergencies in Eating Disorders (MEED) pathway with in-reach support from the community team.  For service users in community who require a non-MEED admission the community team will continue to provide support.  The provider collaborative has an out of area procedure for identifying beds when the service is unable to admit and the service user requires an inpatient bed. |
| **Process for managing Delays in discharge** | The fortnightly Connect Oversight Panel (COP) meeting uses a tracker to monitor and manage delays in discharge or clinically ready for discharge (CRFD). |
| **Any Escalation processes** | The provider collaborative escalation processes include the Connect Oversight Panel (COP) and the West Yorkshire Eating Disorders Provider Collaborative Board. |

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| **Service Line:** | **Regional Eating Disorder, Rehabilitation and Gender Services service Line**  **Inpatient admission to Rehabilitation services.** |
| **Criteria for Admission** | * Primary diagnosis of mental illness which includes psychotic features. * Under the care of secondary mental health services. * Over the age of 18 years. * Service user’s social functioning is so restricted that they have trouble leading a meaningful life AND/ OR ths ervice user’s independent living skills are so restricted that they prevent them from functioning in a community setting without a high level of maintenance AND/ OR the servcei user, despite and intense period of active treatment, continues to experience mental health symotoms on a daily basis which causes them significant distress.   If the service users is detained under the Mental Health Act, they must have and be managing unescorted leave. |
| **Process for Referral** | All referrals are made via Care Director. |
| **Gatekeeping arrangements** | The Recovery Centre gatekeep for the service; referrals are reviewed and allocated daily during the Recovery Centre morning planning meeting. Referrals from locked rehabilitation services and Forensic services are also allocated to medics within the service for joint assessment wth our mental health practitioners. We have an internal referral document that is updated daily.  Assessment outcomes are discussed in a timely manner with the Recovery Lead and a medic and if agreed, the service user will be placed on the waiting list.  The Recovery Centre hold a referral meeting weekly to review referral/ assessment progress and bed state. The referral document is distributed to the relevant stakeholders each week (or sooner if required). |
| **Bed Management process** | Allocated via the Recovery Centre. |
| **Process for managing delays in admission** | Any delays in admission are discussed daily with relevant clinical teams via the Recovery Centre. All delays to admission should be recorded on Datix which is reviewed via our service clinical governance meeting. |
| **Process for managing Delays in discharge** | Clinically Ready for Discharge (CRFD) meetings take place weekly; which includes internally staff and also external stakeholders from the ICB, bed management, Housing Options and ASC (we have developed a Discharge SOP flowchart and TOR for this). |
| **Any Escalation processes** | Items for escalation are identified in the CRFD meeting and actioned as required. |

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| **Service Line:** | **Regional Eating Disorder, Rehabilitation and Gender Services service Line**  **Inpatient admission to High Dependency Rehabilitation Unit (Ward 5, Newsam Centre).** |
| **Criteria for Admission** | When considering making a referral to the service, the service user must meet the following criteria:  The individual:  -has a primary diagnosis of mental illness, which includes psychotic features  -is currently under the care of secondary mental health services  -is over the age of 18  -Their social functioning is so restricted they have trouble leading a meaningful life  OR  Their independent living skills are so restricted that they prevent them from functioning in a community setting without a high level of maintenance.  OR  Despite an intense period of active treatment, they continue to experience mental health symptoms daily, which cause them significant distress. |
| **Process for Referral** | The most common referral sources will be via acute inpatient wards, forensic wards, and out of area locked and forensic services. Referrals from LYPFT Inpatients are made via Care Director, alongside a detailed referral form, providing all relevant clinical information sent to complexrehabreferrals.lypft@nhs.net inbox.  The Complex Rehabilitation Case Manager manages referrals into the service. They will triage, discuss with the ward manager, identify the suitability of the referral and discuss it in the monthly Out of Area panel meeting.  If appropriate for assessment this will be undertsaken in a timely manner so that findings can be discussed at the out of area panel. |
| **Gatekeeping arrangements** | All referrals to Ward 5 Newsam are discussed within the out of area complex rehab panel. |
| **Bed Management process** | Following assessment, if accepted as appropriate transfer will be arranged as soon as a bed is available. The waiting list is discussed at the fortnightly ward referral meeting and at the monthly out of area panel. |
| **Process for managing delays in admission** | Delays in admissions are discussed as above and if waiting for an extended period of time a review of service usr needs will take place at agreed intervals to ensure the referral to the ward remains the least restrictive option. |
| **Process for managing Delays in discharge** | Represtnatives from the ward leadership team have a monthly meeting with Leeds ICB, Adult Social Care, the Out of Area Case manager, CREST and open rehab representatives to review all service users on the ward, during the meting current presentation, barreirs to discharge and actual delayed transfers are discussed and any issues highlighted for escalation to ther senior leadership team. |
| **Any Escalation processes** | Escalation will be via the senior leadership team to the out of area panel. |

**3 IDENTIFICATION OF STAKEHOLDERS**

The table below should be used as a summary. List those involved in development, consultation, approval and ratification processes.

|  |  |
| --- | --- |
| **Stakeholder** | **Level of involvement** |
| Heads of operations | Consultation and development |
| Operational Delivery and performance Group | Consultation |
| Adult services Clinical governance | Consultation |
| Service operational managers | Consultation and devleopment |
| Capacity and discharge support service | Consultation |
| Policy and Procedures Group | Ratification |

**4 REFERENCES, EVIDENCE BASE**

NICE guidance: Transition between inpatient hospital settings and community or care home settings for adults with social care needs

Leeds discharge and transfer of care policy

NICE guidance: Chapter 35 Discharge Planning

**5 EQUALITY IMPACT**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have/have not\* identified any potential negative impacts for any of the nine protected groups.

Print name: James Woolhouse

Job title: Strategic Develeopment Manager

Date: 23/11/23

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net).

\*delete as appropriate

**CHECKLIST**

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This is a checklist and is part of the working papers. It does not form part of the final version of the procedural document to be uploaded to staff net.

|  | **Title of document being newly created / reviewed:** | **Yes / No/** |
| --- | --- | --- |
| **1.** | **Title** |  |
|  | Is the title clear and unambiguous? | *yes* |
|  | Is the procedural document in the correct format and style? | *yes* |
| **2.** | **Development Process** |  |
|  | Is there evidence of reasonable attempts to ensure relevant expertise has been used? | *yes* |
| **3.** | **Content** |  |
|  | Is the Purpose of the document clear? | *yes* |
| **5.** | **Approval** |  |
|  | Does the document identify which committee/group will approve it? | *yes* |
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|  | Has the declaration been completed? | *yes* |
| **7.** | **Review Date** |  |
|  | Is the review date identified? | *yes* |
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